STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	06/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 9, 10, 11, 12 & 13, 2014 Facility number: 000035 Provider number: 155089 AIM number: 100266250 Survey team: Leslie Parrett RN, TC Angel Tomlinson RN Barbara Gray RN Diana Sidell RN Census bed type: SNF/NF: 50 Total: 50 Census payor type: Medicare: 5 Medicaid: 40 Other: 5 Total: 50 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 19, 2014 by Cheryl Fielden, RN.	F000000	**Defeciency ID: F _ 0000** **Completion Date: July 13, 2014** **Plan of Correction** F0000 Preparation and/or execution of This Plan of Correction in general or any corrective action set forth herein, in particular, does not constitute an admission or agreement by Heritage House of New Castle of the facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed solely because of provisions of federal and/or state laws. Heritage House desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective July 13, 2014. This building respectfully requests consideration for paper compliance from the Plan of Correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is			

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	verified appropriate corrective action must be taken. Based on interview and record review the facility failed to report an allegation of abuse to the Administrator immediately resulting an employee continuing to work after the allegation and delayed the investigation of the allegation of abuse for 1 of 3 residents reviewed for abuse (Resident #1). Finding include: Interview with Resident #1 on 6/11/14 at 10:25 a.m., indicated CNA #10 did not treat her good and was rude to her. When queried what did CNA #10 do that she felt was rude, Resident #1 indicated CNA #10 would tell the resident if she did not like the way she did her care she would leave the resident and not give her care. Resident #1 indicated CNA #10 would tell her when she was giving her incontinence care if she did not like the way she cleaned her up she would leave the resident wet. Resident #1 indicated she reported CNA #10 to the Director Of Nursing (DON) and she felt like it was taken care of. Resident #1 indicated CNA #10 was no longer allowed to give her care. Interview with CNA #1 on 6/11/14 at 12:39 p.m., indicated she was giving	F000225	Heritage House will continue to ensure that all alleged violations of verbal abuse are thoroughly investigated and prevent further potential abuse while the investigation is in process. All allegations of abuse will be reported to officials in accordance with State Law. 1. The alleged incident of verbal abuse was reported to the DON and Administrator on 6/10/14 and to the surveyors on 6/11/14. The allegation of abuse was thoroughly investigated when reported to the DON on 6/10/14. CNA #10 was immediately suspended pending the investigation and was still on suspension when the surveyors were notified. 2. Any resident making an allegation of verbal abuse has the potential to be affected. All residents making any type of allegation of alleged verbal abuse will be reported to the appropriate officials in accordance with State law. 3. All staff will be inserviced on the proper reporting of allegations of abuse by7/13/2014. All new hires will be educated on abuse prohibition and proper reporting. 4. All accusations of abuse will be investigated and reported to the appropriate State agencies. Attachment #1. The DON or designee will monitor reportable log weekly for 3 months then monthly for 3 months to ensure	07/13/2014

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	Resident #1 a bath on 5/31/14 and the resident reported to her that CNA #10 was rude and hateful to her. CNA #1 indicated the resident also reported to her that CNA #10 would tell her she would come back to give her care and then not come back and would refuse to give the resident care. CNA #1 indicated she reported the allegations to RN #2 on 5/31/14. When queried how did she know the date of this incident, CNA #1 indicated she knew because it was the last weekend she had worked. Interview with CNA #10 on 6/11/14 at 1:59 p.m., indicated Resident #1 had been rude to her since her employment had began in January 2014. CNA #10 indicated she would not give Resident #1 care without another staff person present. CNA #10 indicated Resident #1 would ask for other staff to position her pillow for her because she did not do it correctly. CNA #10 indicated she had never been rude of mean to Resident #1, even when the resident mistreated her. Interview with Resident #1 on 6/12/14 at 10:36 a.m., indicated she reported to CNA #1 a week or two ago that CNA #10 was rude and hateful to her. Resident #1 indicated CNA #1 was cleaning her up when she reported CNA #10 to her. Resident #1 indicated she did not know if		compliance. These reportables will be reported to the QA Committee and recommendations followed.	

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	CNA #1 reported it to the nurse. Resident #1 indicated no other nurse besides the DON had talked with her about the incident. Interview with the DON on 6/12/14 at 1:30 p.m. indicated on 6/10/14 Resident #1 reported to her that CNA #10 was mean to her and yelled at her. The DON indicated CNA #1 did not report that Resident #1 had complained to her about CNA #10 until 6/11/14. The DON indicated CNA #1 told her she reported the allegation to RN #2. Interview with RN #2 on 6/12/14 at 3:07 p.m., indicated no staff had reported any allegations of abuse related to Resident #1. RN #2 indicated CNA #10 reported to her that Resident #1 was mean and nasty to her. RN #2 indicated CNA #10 would not give Resident #1 care without another staff person present. RN #1 indicated CNA #10 would answer Resident #1's call light and would let her know when another staff member was available to assist her she would give her care. Interview with the Administrator on 6/12/14 at 3:48 p.m., indicated RN #2 or CNA #1 had reported any allegations of abuse to her related to Resident #1 or CNA #10. The Administrator indicated			

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	an allegation of abuse was reported to her on 6/10/14 related to Resident #1 and CNA #10 by the DON. The Administrator indicated the DON reported an allegation that CNA #10 yelled at Resident #1. The Administrator indicated CNA #10 was told not to report to work until the investigation was completed. Review of the record of Resident #1 on 6/12/14 at 11:00 a.m., indicated the resident's diagnoses included, but were not limited to, mild retardation, obesity, pain, dementia with behaviors and seizures. The Quarterly Minimum Data Set (MDS) assessment dated, 5/8/14 indicated the following: Brief Interview for Mental Status (BIMS) score was 11- moderately impaired, bed mobility- extensive assistance of two people, transfer- activity did not occur, walk in room- activity did not occur, dressing- extensive assistance of two people, toileting- extensive assistance of two and personal hygiene- extensive assistance of one. Review of the nursing and cna schedule as worked provided by the DON on 6/11/14 indicated RN #2 and CNA #1 worked together on day shift on 5/31/14. CNA #1 did not work the weekend after			

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	5/31/14. The CNA schedule as worked indicated CNA #10 worked 5 days after 5/31/14 when Resident #1 reported the allegation of abuse. The abuse policy provided by the Administrator on 6/11/14 at 10:06 a.m. indicated if any allegation of abuse are voiced an investigation will be initiated. "Should an occurrence of abusive behavior be reported or witnessed, the Administrator and Director Of Nursing shall be notified immediately." "The alleged violation shall be thoroughly investigated by the Administrator or his/her designee." "The facility must prevent further potential abuse while the investigation is in process." "For example, an individual who has been alleged as exhibiting abuse behavior should not be permitted to continue to care for residents until an investigation has been completed and the allegation found to be unsubstantiated." 3.1-28(a)			
F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement			

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	written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review the facility failed to implement the policy of abuse by not protecting residents, implementing an investigation and reporting an allegation of verbal abuse and neglect for 1 of 3 residents reviewed for abuse/neglect (Resident #1). Finding include: Interview with Resident #1 on 6/11/14 at 10:25 a.m., indicated CNA #10 did not treat her good and was rude to her. When queried what did CNA #10 do that she felt was rude, Resident #1 indicated CNA #10 would tell the resident if she did not like the way she did her care she would leave the resident and not give her care. Resident #1 indicated CNA #10 would tell her when she was giving her incontinence care if she did not like the way she cleaned her up she would leave the resident wet. Resident #1 indicated she reported CNA #10 to the Director Of Nursing (DON) and she felt like it was taken care of. Resident #1 indicated CNA #10 was no longer allowed to give her care. Interview with CNA #1 on 6/11/14 at 12:39 p.m., indicated she was giving	F000226	F226 Heritage House will continue to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1. This allegation of verbal abuse made by resident #1 re: CNA #10 was reported to the DON and Administrator on 6/10/14. CNA #10 was immediately suspended pending the investigation. A thorough investigation was done on the allegation of alleged verbal abuse made by resident # 1, that allegation was not substantiated. 2. Any resident who makes an allegation of verbal abuse has the potential to be affected. All resident allegations were reviewed for the last 6 month. All resident allegations of any type of abuse will be reported to the appropriate State agencies within 24hours of the incident and an investigation will be done on all allegations. 3. All resident allegations of any type of abuse will be reported to the appropriate State agencies within 24hours of the incident and an investigation will be done on all allegations. See attachment #2. All staff will be inserviced on abuse by 7/13/14. 4. The DON or her designee will monitor all ISDH	07/13/2014

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			

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	Based on observation, interview and record review the facility failed to follow the care plan for Dental Services for 1 of 4 residents that met the criteria for Dental Services. (Resident # 53) Findings include: Resident observation on 6/9/14 at 9:10 a.m., indicated Resident # 53 was in his room lying in bed with eyes open, when this writer approached Resident for interview he closed his eyes and would not respond. Interview with LPN # 4 on 6/9/14 at 9:20 p.m., indicated Resident # 53 does not like to be bothered while he's in bed for his nap. Observation on 6/9/14 at 11:40 a.m. of Resident # 53 indicated he was up in his room and was pleasantly confused and not interviewable. On 6/10/14 at 9:41 a.m., an interview with Resident # 53's daughter indicated Resident lost his lower denture at the facility in December and denture has not been found or replaced at this time. Daughter indicated she told "one of the girls" does not remember the name of person she notified of missing dentures.	F000282	Heritage House will continue to provide or arrange for services to be provided to residents by qualified persons in accordance with each residents care plan. 1. Resident #53 has been seen by the dentist on both 6/18/14 and 6/26/14. Impressions have been made for replacement lower dentures. Resident #53 has had his care plan revised and updated to include current plans to ensure resident is seen by the provider while he is awake. 2. Any resident who had a care plan that stated they have a history of refusing ancillary services due to their refusal to get up and allow service provider to see them. Care plans will be review and revised as needed for all residents with the same identified problem by 7/13/14. 3. Staff will be inserviced on the timely reporting of the need for ancillary service for the residents. A new ancillary services request form has been developed. Attachment #3. All resident care plans re: ancillary services will be reviewed and revised as needed by 7/13/14. 4.All requests for ancillary services will be reviewed and the residents name added to the list to see the needed ancillary services provider. The Social Services Director or their designee will review the requests weekly for 3 months then monthly for 3 months. This information will be reported to the QA	07/13/2014

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	"No it wasn't a nurse I believe it was a CNA. She said she would notify laundry so they would look for them and someone would let me know if they were found or not. No one has gotten back with me about his dentures and I don't know if they have made a dental appointment for him yet." Review on 6/11/14 at 10:15 a.m., of Resident # 53's record indicated dental services oral assessment forms on 2/11/14 and 3/12/14, which indicated Resident # 53 refused dentures on those dates. Review of Resident # 53's inventory sheet indicated Resident had upper and lower dentures on admission. On 6/13/14 at 11:15 a.m., an interview with the Social Services Director indicated she was notified on 2/10/14, "daughter notified me Resident # 53's lower denture was missing. I was not notified until his daughter notified me on 2/10/14. I placed him on the list to be seen by the dentist the next day which was 2/11/14." "The protocol for lost items is I start a concern form, if an item is not found the facility will replace clothing, money, smaller items like that but if it's dentures or eyeglasses we go through services such as medicaid. We try to replace items		Committee and recommendations followed.	

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	155089	A. BUILDING 00 B. WING	06/13/2014

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	if we can or use resident services like medicaid. "When I was talking with the dental services person, they process it through medicaid and he has to have liability to enroll in the program or send a medicaid prior authorization that could take up to 6 weeks." "Resident # 53 was in bed napping when the dentist was here on 2/11/14 and on 3/12/14, I'm sure that is why he refused dental services at that time, he doesn't like to be disturbed when he's napping." Social Services Director indicated she was in the dining on 6/12/14 for evening meal when Resident # 53's daughter asked him if he would like lower dentures and Resident indicated yes, he would like to have them for eating. On 6/13/14 at 11:45 a.m., Social Services provided a care plan for dental services dated 2/11/14 indicated: Problem: Resident likes to get up on his own time. He has a history of refusing ancillary services due to his refusal to get up and allow service provider to see him. Goal: Residents care needs will be met, review every 90 days. Approach: 1. Allow Resident to get up when he wishes, but always return to ask him if he would like to see the provider. 2. Approach with alternate caregiver. 3. If provider is willing and has the			

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	means, attempt to have provider explain to the Resident why he is here and what he wants to help with. If feasible, have the Resident seen in his room where he is at. 4. Plan ahead and if Resident is already up, have him seen at that time before he goes back to his room. Interview on 6/13/14 at 2:15 p.m., with the Administrator indicated "I was not notified of Resident # 53 losing his lower denture until February when his daughter notified the Social Services Director. An investigative report was done as soon as I was notified." Administrator indicated Resident # 53 would be placed on dental schedule for dental services visit next week on 6/18/14. On 6/13/14 at 2:30 p.m., interview with Housekeeping Director indicated no she was not notified Resident # 53 was missing his lower denture until February and no dentures had been found in the laundry. Review on 6/13/14 at 2:45 p.m., of Resident/ Family Concern Form provided by the Administrator dated 2/10/14 indicated Resident # 53's daughter states that resident is missing his bottom denture - fears that he has thrown them in the trash - (been missing for a while -			

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	thought that they would " turn up." Resident has been referred to dental services- on list to be seen tomorrow. Follow- up dated 2/27/14 Resident reportedly refused the dentist when he visited but will be placed on the list for next visit. On 6/13/14 at 2:50 p.m., Policy for lost or stolen items was provided by the Director of Nursing indicated: Procedure... 4.) Following investigation, it shall be at discretion of the Administrator as to replacement of lost or stolen items based upon individual circumstances. 3.1-35(g)(2)(1)			
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F000323	F323 Heritage House will	07/13/2014

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	Based on observation, record review, and interview, the facility failed to ensure a dependent resident was free from accidents in that one resident was left unattended with her breakfast tray, spilled a cup of hot water on herself and received second degree burns. This affected 1 of 4 residents affected in a sample of 4 reviewed for accident/hazards. (Resident #3) Findings include: Resident #3's record was reviewed on 6/11/14 at 11:18 p.m. The record indicated Resident #3 was admitted with diagnosis that included, but were not limited to, high blood pressure, type two diabetes, angina, dementia, pain, anxiety, depression, Alzheimer's disease, and cellulitis. A quarterly Minimum Data Set Assessment (MDS), dated 2/7/14, indicated Resident #3 was severely impaired, never/rarely made decisions in cognitive skills for daily decision making, and required extensive assistance of one for eating. A quarterly MDS, dated 5/20/14, indicated Resident #3 was severely impaired, never/rarely made decisions in cognitive skills for daily decision		continue to ensure that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents. 1. Resident #3 will not be left unattended with her meal tray that contains hot beverages. 2. All residents who require assistance with meals and choose to drink hot beverages have the potential to be affected. All dependent residents who requires assistance with meals will not have their food trays that contain hot liquids left in their rooms when not being fed. 3.All dependent residents will not have their food trays, that contain hot beverages, left in their rooms when not being fed. An Eating Assistance Log has been developed and all residents needing assistance will be monitored to ensure that no food trays containing hot beverages are being left in the room when the resident is not being fed. All staff to be inserviced by 7/13/14. 4. Nursing Dept. will keep an Eating Assistance Log on all residents requiring assistance with their meals to ensure that resident trays containing hot beverages are not left in resident rooms when the resident is not being fed. Attachment #4. The DON or her designee will monitor log 5 times a week for 3 months, 1 time a week for 3 months. Findings will be reported to the	

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	making, and required extensive assistance of one for eating. Nurse's notes dated 6/5/14, at 8:30 a.m., indicated: "Resident found [with] cup of hot water lying in bed to left hip, lid in place. CNA reported to this nurse. CNA stated asked resident if it hurt, resident stated "no it's okay." A physician's progress note dated 6/4/14, indicated: "Spilt hot coffee on skin, 2 [second degree] burns, blister popped, neosporin applied...." A progress note from [local physician's office], dated 6/10/14, and signed by a nurse practitioner, indicated: "...Chronic problems: burn from hot water spill last week (L) hip. Having been using neosporin oint (ointment). C/O (complained of) burning. (L) hip [with] approx 7 cm (centimeter) dia[meter] area pink open skin [with] moderate amt (amount) thin yellow slough & peeling skin @ edges. Burn periphery [with] narrow band erythema (redness). Assessment & plan: 2nd degree burn (L) hip, switch to silvadene, monitor...." Physician's telephone orders, dated 6/5/14, indicated: "Apply Neosporin plus to left hip areas BID (twice a day) x 10 days."		QA committee and recommendations followed.	

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Physician's telephone orders dated 6/10/14, indicated: "Stop neosporin to burn, start silvadene & foam dressing qd (every day). Indication: 2nd degree burn (L) hip."

A care plan for "Potential for skin breakdown" dated 4/24/14, indicated a goal: "Will have no skin breakdown X 90 d (days). Approach: (1) Monitor skin Q (every) shift for S/Sx's (signs and symptoms) of potential skin breakdown (E.G. redness/discoloration or open areas). Alert charge nurse if observed for notification of physician as needed to obtain TX (treatment) orders. (2) Apply lotion to skin 2X daily...(8) Avoid exposure to hot water and use mild cleansing agent and gentle touch to minimize irritation and dryness of skin...17. Apply neosporin plus to (L) hip area bid X 10d. [Discontinued] Monitor areas for s/sx's of infection, 6-5-14. Notify MD if appears worse to 2nd degree burn to (L) hip. 18. Silvadene et foam dressing qd to (L) hip burn areas. 6-10-14."

A care plan for "Res (resident) requires extensive to total assist with ADL'S (activities of daily living). Goal: Resident will wash own face with cues after washcloth is wet with warm water

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	X90 d. Approaches...10. Res requires fed at times, allow her to attempt to feed herself, if unable, staff to feed her. 12. Provide and encourage fluids while in room when giving ADL care...18. Pt will only have hot beverages [with] supervision. 6-5-14." A Fax/Incident Report, dated 6/5/14 at 8:10 a.m., indicated "...Brief description of Incident: Resident found lying in bed with cup of hot water lying beside her with lid still intact. When asking resident how the cup got in the bed resident stated "I dropped my water." When asked if it hurt, resident stated "no it doesn't hurt, It's okay." Type of Injury/Injuries: Two blisters noted to left hip (1) 6.0 cm X 4.0 cm X <0.1 cm. (2) 3.0 cm X 1.0 cm X <0.1 cm. Immediate action taken: Notified MD, family, APS, Ombudsman, obtained treatment orders. Preventative measures taken: Resident will only be served hot beverages with supervision." During an interview, on 6/12/14 at 11:40 a.m., the Director of Nurses (DoN) indicated the morning Resident #3 pulled the cup into her bed and burned herself, the staff member who was going to assist her with breakfast had to send another resident out to the hospital, and she couldn't get to her right away. She indicated her tray was left at her bedside			

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	and the resident pulled the cup into the bed with her and that's how she was burned, but usually staff take her tray and stay with her to feed her. She said the nurse had left her tray about two feet from the resident, and she usually doesn't reach for her tray, the nurse got called out of the room, they didn't think she could reach her tray, and Resident #3 was never given her tray unassisted. On 6/12/14 at 11:47 a.m. CNA #5 indicated she had fed Resident #3 this morning at breakfast and she did not have any hot beverages on her tray. CNA #5 was observed feeding Resident #3 the noon meal which also did not have any hot beverages on the tray. On 6/12/14 at 3:28 p.m., with RN #2, Resident #3's wounds were observed. There were two areas on the left outer hip, one large area, about 5 cm by 6 cm and the other was about 3 cm by 2 cm, both had open areas in the center where the top layer of skin was healing, and had cream colored areas across the open part, with pink edges and no signs of infection. A policy titled "Accident and Supervision to Prevent Accidents", with a last review date of 1/10/13, was provided by the Administrator on 6/13/14 at 10:40 a.m. The policy indicated, but was not limited			

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	to, "Accident: Refers to any unexpected or unintentional incident or chain of events which may or may not result in injury or illness to a patient. This does not include adverse outcomes that are a direct consequence of treatment or care provided in accordance with standards of practice. Hazards may include but not limited to aspects of physical plant, equipment and devices that are defective or are not used properly (per manufacturer specifications) are disabled/removed or are not individually adapted or fitted to the patient needs. Avoidable Accident: Identify environmental hazards and individual patient risk of an accident including the need for supervision; and/or: Evaluate/analyze the hazards and risk; and/or: Implement interventions, including adequate supervision, consistent with patient needs, goals, plan of care and recognized standards of practice in order to reduce the risk of an accident; and/or: Monitor the effectiveness of the interventions and modify the approaches as necessary in accordance with relevant care standards. Unavoidable Accident: Identify environmental hazards and individual patient risk of an accident, including the need for supervision...." 3.1-45(a)(1)			

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	3.1-45(a)(2)			
F000412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observaton, interview and record review the facility failed to follow Care Plan interventions to provide dental services to meet the needs of 1 of 4 residents that met the criteria for dental services. (Resident # 53) Findings include: Resident observation on 6/9/14 at 9:10 a.m., indicated Resident # 53 was in his room lying in bed with eyes open, when	F000412	Heritage House will continue to provide or obtain from an outside resource routine and emergency dental services to meet the needs of each resident; will if necessary, assist the resident in making appointments; and by arranging transportation to and from the dentist's office; and will promptly refer residents with lost or damaged dentures to a dentist. 1. Social Services was notified on 2/10/14 by resident #53 daughter that resident was missing his bottom denture and fears he has thrown them in the trash.	07/13/2014

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	this writer approached Resident for interview he closed his eyes and would not respond. Interview with LPN # 4 on 6/9/14 at 9:20 p.m., indicated Resident # 53 does not like to be bothered while he's in bed for his nap. Observation on 6/9/14 at 11:40 a.m. of Resident # 53 indicated he was up in his room and was pleasantly confused and not interviewable. On 6/10/14 at 9:41 a.m., an interview with Resident # 53's daughter indicated Resident lost his lower denture at the facility in December and denture has not been found or replaced at this time. Daughter indicated she told "one of the girls" does not remember the name of person she notified of missing dentures. "No it wasn't a nurse I believe it was a CNA. She said she would notify laundry so they would look for them and someone would let me know if they were found or not. No one has gotten back with me about his dentures and I don't know if they have made a dental appointment for him yet." Review on 6/11/14 at 10:15 a.m., of Resident # 53's record indicated dental services oral assessment forms on		Resident #53 was added to list to be seen by the dentist on 2/11/14 and again on 3/12/14. Resident # 53 refused to see the dentist both times. Resident #53 was seen by the dentist on both 6/18/14 and 6/26/14. Impressions have been made for replacement lower dentures. 2. Any resident who had the need for routine or emergency dental services and refused to be seen for any reason. A new Social Services Referral Form has been developed and will be put into use by 7/13/14. Attachment #3. Social Services will be required to schedule the needed ancillary services, address lost items or other concerns promptly.This will depend on the availability of an appointment with the needed provider. 3. Staff will be inserviced on the timely reporting using the Social Service Referral Form and reporting of lost items by 7/13/14. A new Social Services Referral Form has been developed. See attachment #3. See attachment #5 for policy on lost items. Social services is to be notified promptly of an emergency request for services and/or lost items. Social Services or their designee will address the issues indicated on the forms and call the needed ancillary services provider and schedule an appointment promptly, if indicated, depending on the availability of an appointment. 4. All Social	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	denture until February when his daughter notified the Social Services Director. An investigative report was done as soon as I was notified." Administrator indicated Resident # 53 would be placed on dental schedule for dental services visit next week on 6/18/14. On 6/13/14 at 2:30 p.m., interview with Housekeeping Director indicated no she was not notified Resident # 53 was missing his lower denture until February and no dentures had been found in the laundry. Review on 6/13/14 at 2:45 p.m., of Resident/ Family Concern Form provided by the Administrator dated 2/10/14 indicated Resident # 53's daughter states that resident is missing his bottom denture - fears that he has thrown them in the trash - (been missing for a while - thought that they would " turn up." Resident has been referred to dental services- on list to be seen tomorrow. Follow- up dated 2/27/14 Resident reportedly refused the dentist when he visited but will be placed on the list for next visit. On 6/13/14 at 2:50 p.m., Policy for lost or stolen items was provided by the Director of Nursing indicated: Procedure... 4.) Following investigation,			

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	155089	A. BUILDING 00 B. WING	06/13/2014

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	it shall be at discretion of the Administrator as to replacement of lost or stolen items based upon individual circumstances. 3.1-24(a)(3)			
F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.			

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	(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility staff failed to wash their hands after removing a soiled wound dressing, for 1 of 1 residents observed for dressing change, of 1 resident who met the criteria for pressure ulcer. (Resident #56) Findings include: Resident #56's record was reviewed on 6/11/14 at 9:59 a.m. Diagnoses included but were not limited to, Multiple Sclerosis and pressure ulcer. Resident #56's quarterly Minimum Data Set (MDS) Assessment dated 4/23/14, indicated she was totally dependent on 2 persons for bed mobility and transfers. She did not walk and utilized a wheelchair. She required total assistance of 1 person for dressing and personal hygiene. She had a diagnosis of Multiple	F000441	Heritage House continues to have an established and will maintain an Infection Control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.1.Staff will wash hands when they change their gloves during a dressing change on resident #56.2. All other residents requiring a dressing change have the potential to be affected. Nursing staff will follow the policy on hand washing and dressing changes.3. Nursing staff will be inserviced on hand washing and dressing changes by 7/13/14. Infection Control Nurse will randomly observe dressing changes and hand washing and continue to educate staff as necessary. A log will be kept. Attachment #6.4. Administrator/DON or their designee will monitor 2 times a week for 3 months then 1 time a	07/13/2014

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	Sclerosis and an unhealed stage IV pressure ulcer. A physician's order for Resident #56 dated 5/28/14, indicated she would receive a wet to dry dressing treatment to her coccyx pressure ulcer 2 times a day. A "Skin Condition Report" for Resident #56 dated 6/3/14, indicated she had a stage IV coccyx pressure ulcer measuring 3.1 cm (centimeters) long, 3.3 cm wide, and 3.2 cm deep. The wound color was red with serosanguineous (composed of serum and blood) drainage. Resident #56 was observed receiving a wet to dry dressing treatment to her coccyx pressure ulcer on 6/10/14 at 2:33 p.m. LPN #4 assisted by holding Resident #56 on her right side while RN #3 provided the treatment. LPN #4 and RN #3 were both wearing gloves. RN #4 removed the old gauze that was packed in the wound and the old dressing covering the wound, that were both wet with serosanguineous drainage. She changed her gloves and cleaned the wound using normal saline, wound cleanser, and a washrag. She changed her gloves and packed the wound with sterile gauze wet with normal saline. She then placed Permafoam over the gauze packed in the wound. The wound bed was red and		week for 3 months. A report on findings will be given to the QA Committee and their recommendations followed.	

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	appeared to be approximately a half dollar size in diameter. On 6/10/14 at 3:05 p.m., RN #4 indicated she had not washed her hands after removing the previous dressing from Resident #56's coccyx wound during her dressing change. She indicated Resident #56 had not had excessive drainage that would be a concern for contamination or soilage for her. A Nurses Note dated 6/11/14 at 3:00 p.m., indicated Resident #56's skin had been assessed. Her coccyx wound measured 3.4 cm long by 3.3 cm wide by 3.0 cm deep. The wound base was red with a moderate amount of serosanguineous drainage noted to the dressing. A "Dressing - Clean Technique" policy and procedure provided by the DON (Director of Nursing) on 6/13/14 at 2:42 p.m., indicated the following: "Purpose: A clean dressing technique is used to provide an appropriate and safe environment conductive of wound healing. Procedure: 1. Verify physician order and identify Resident. 2. Explain procedure to Resident and provide privacy. 3. Wash hands. Put on gloves. 4. Remove soiled dressing and discard into designated waste receptacle. 5.			

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	Remove gloves, wash hands, and put on a pair of clean gloves....". A "Dressing, Moist" policy and procedure provided by the DON on 6/13/14 at 2:42 p.m., indicated the following: Purpose: Moist dressings are used to debride a wound and provide a physiological environment conductive to wound healing. Procedure: 1. Identify Resident. 2. Explain procedure to Resident and provide privacy. 3. Wash hands. Put on gloves. 4. Remove previous dressing; dispose of properly. 5. Remove gloves; dispose of properly. 6. Wash hands. Put on clean gloves....". 3.1-18(l)			